United Nations ST/IC/2013/18

Secretariat

10 June 2013

Information circular*

To: Members of the staff and participants of the after-service health insurance programme

From: The Controller

Subject: **Renewal of the United Nations Headquarters-administered health insurance programme, effective 1 July 2013**

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General

1. The purpose of the present circular is to provide information regarding health insurance plans administered by United Nations Headquarters and to announce the 2013 administrative and plan changes, including premium and contribution rates changes.

2. Changes in the premium and contribution rates will take effect on 1 July 2013 for the following health insurance programmes:

(a) Aetna PPO/POS II: increase of 3.28 per cent;

(b) Empire Blue Cross PPO: increase of 4.78 per cent;

(c) HIP Health Plan of New York: increase of 5.54 per cent;

(d) Cigna Dental PPO: increase of 2.55 per cent;

(e) Vanbreda International: increase of 9.85 per cent.

Please refer to annex I for more details.

3. A number of plan changes will be implemented for the following medical insurance plans effective 1 July 2013:

(a) Aetna PPO/POS II: the annual deductible for out-of-network services will be increased from $175 per person to $250 per person and from $525 per family to $750 per family;

(b) Empire Blue Cross PPO: the annual deductible will be increased from $200 per person to $250 per person and from $600 per family to $750 per family;

(c) HIP Health Plan of New York: the plan will be closed to new subscribers (i.e. active or retired staff members). Subscribers who are currently covered may remain in the plan, and any changes related to their eligible household members will be accepted. However, a current subscriber who switches to another United States plan during the 2013 annual campaign will not be allowed to return to the HIP plan in future annual campaigns;

(d) Vanbreda International: the following changes will be implemented:

(i) Eye examination to determine the dioptre by an ophthalmologist, optometrist or optician will be covered every 12 months at the current reimbursement rate;

(ii) Prior approval from Vanbreda medical consultants for planned or non-emergency hospitalizations and selected outpatient treatments (i.e. chemotherapy, haemodialysis and radiological treatments) in the United States of America will be strictly enforced. Prior approval is based on the medical necessity of the treatment. Approval for the United States will be given only if the medical consultant agrees that care can only be rendered in the United States. The Vanbreda medical consultant will consider the following as a medical emergency: "medical treatments, including follow-up visits, which are undertaken due to an unplanned, sudden and acute illness or injury and which, for medical reasons, cannot be delayed or postponed." In case of women who go into labour after their thirty-second week of pregnancy, the delivery and care rendered to the newborn child are not considered a medical emergency;

(iii) Failure to secure prior approval from Vanbreda medical consultants for planned or non-emergency hospitalization and selected outpatient treatments in the United States will result in the suspension of the Major Medical Benefits Plan component when reimbursing claims;

(iv) Increase in the annual deductible for services received in the United States from $200 per insured person to $1,200 per person and from $600 per family to $3,600 per family.

4. Staff members and retirees currently enrolled in the Vanbreda plan who intend to seek medical care in the United States on a regular basis should consider enrolling in a United States-based plan effective 1 July 2013.

5. The Health and Life Insurance Committee has approved a one-month premium holiday for participants of the Aetna PPO/POS II plan for the plan year effective 1 July 2013.

Costing of United Nations insurance programmes

6. All plans administered by United Nations Headquarters other than HIP are self-funded health benefit plans; they are not insured programmes. The cost of the programme is entirely based on the medical services provided to plan participants and directly reflects the level of utilization of the plan by its participants. The yearly contributions paid by the participants and the portion of the premium paid by participating United Nations entities are used to cover claim costs plus a fixed administrative fee per primary subscriber (i.e. staff member or retiree), which represents less than 5 per cent of the total programme cost. Costs are calculated as follows:

(a) All costs of the United States-based plans are borne by the United Nations and by plan participants collectively through a "two thirds to one third" cost-sharing arrangement approved by the General Assembly;

(b) All costs of the Vanbreda plan are borne by the United Nations and by plan participants collectively through a 50/50 cost-sharing arrangement approved by the General Assembly;

(c) Neither the plan participants' nor the organizations' portions of the monthly premium are prorated. The full monthly premium amount will be collected regardless of the date on which coverage begins within a month.

7. Aetna, Empire Blue Cross, Cigna and Vanbreda provide administrative services to the United Nations on the basis of "administrative services only" agreements entered into by the United Nations with those carriers. Those arrangements make it possible for the United Nations to use the carrier's eligibility and claim processing expertise and benefit from the direct billing and discounted services that the carriers have negotiated with medical providers in their networks.

8. Except for HIP, the United Nations medical insurance and dental insurance programmes are "experience-rated". This means that each year's premiums are based on the cost of medical or dental treatment received by United Nations participants in the prior year, plus the expected effect of higher utilization and medical inflation, plus the appropriate allowance for administrative expenses for the new plan year. The underlying elements in the increasing cost of health insurance for participants are therefore:

(a) Continuing growth in utilization of services and medications;

(b) Continuing increases in prices for services and medications; and

(c) Expenses that are incurred in high-cost health-care markets.

In a year following a period of heavy utilization, premium increases are likely to be relatively high. Conversely, if utilization in the prior year has been moderate, the premium increase in the subsequent year will also likely be moderate. The yearly premiums are calculated to meet medical expense and administration costs in the forthcoming 12-month contract period. The underlying cost of medical expenses is normally about 95 per cent of the premium, and administrative expenses make up the remaining 5 per cent. Each year the expected overall costs of the programme are first expressed as premiums and then borne collectively by the participants and by the Organization in accordance with the cost-sharing ratios set by the General Assembly.

9. The HIP plan is "community-rated". This means that HIP premiums are based on the average medical cost of all employers that purchase the same kind of coverage from HIP and not just that of United Nations participants. The New York State Insurance Department regulates the premium rates for community-rated programmes, such as HIP.

10. Each of the plans in the United Nations Headquarters health insurance programme provides protection against the high cost of health care, whether it involves preventive care, serious illness or injury. Premiums collected are pooled together, from which the claims are paid. In order to ensure the viability and affordability of the plans, subscribers are expected to participate and contribute to the plan through the regular payment of premiums regardless of their current health condition and need for coverage. Strict rules for enrolment in and termination from the plan have been put in place to prevent abuse and participation on an "as needed" basis only. Rebates based on one's consumption are not permitted.

11. Cost containment is also available through wellness initiatives. Health improvements and cost reductions have started to become apparent as staff and retirees use the disease management and wellness features available to Aetna and Empire Blue Cross participants through the ActiveHealth programme implemented in December 2008. Plan participants are encouraged to make full use of the ActiveHealth programme so as to obtain maximum benefits from both a health/wellness perspective and plan cost perspective. Aetna and Empire Blue Cross participants are strongly encouraged to access the ActiveHealth website and make full use of the programme.

Annual campaign

12. The annual campaign for 2013 is being held from 20 May to 15 June 2013 and is open only to active staff members. The staff members of the Health and Life Insurance Section are available to provide information and answer specific questions regarding the health plans being offered to staff. Staff may send their questions or completed forms to the e-mail address or fax number indicated below or consult the Health and Life Insurance Section's website. In addition, the Insurance and Disbursement Service offers in-person client services at the location and hours indicated below:

Health and Life Insurance in-person client service

Room FF-300, 304 East 45th Street, New York, New York 10017

Client service hours: 1 p.m.-4 p.m. Monday, Tuesday, Thursday, Friday

9.30 a.m.-4 p.m. Wednesday

E-mail: insurance-unhq@un.org

Website: www.un.org/insurance

Tel.: 212 963 5804 — for general enquiries

Fax: 917 367 1670

13. Staff members are reminded that the 2013 annual campaign is the only opportunity until the next annual campaign in May 2014 to: (a) enrol in or terminate enrolment in the United Nations Headquarters-administered insurance programme; (b) change to a different plan; and/or (c) add or terminate coverage for eligible dependants from their plan, aside from the specific "qualifying" events, such as marriage, divorce, death, transfer and birth or adoption of a child, for which special provisions for enrolment between campaigns are established. Please refer to paragraphs 32 and 33 for information on the qualifying events for enrolment and termination outside the annual campaign period.

14. A staff member enrolled in the Cigna dental plan must continue such coverage for at least 12 months before elections for discontinuation of coverage during the annual campaign will be accepted.

15. Effective 1 July 2013, Aetna, Empire and Vanbreda insurance coverage must be maintained for at least 12 months as well before elections for discontinuation of coverage during the annual campaign will be accepted. Staff members on the Vanbreda plan who switch to a United States plan as a result of dependants residing in the United States must remain in the United States plan for at least 12 months before elections to switch back to the Vanbreda plan will be accepted.

16. Individuals enrolled in the United Nations Headquarters-administered after-service health insurance are allowed to make a plan change once every two years only, in accordance with paragraph 8.2 of administrative instruction ST/AI/2007/3 on after-service health insurance.

17. The effective date of insurance coverage for all campaign applications, whether for enrolment, change of plan or change of family coverage, is 1 July 2013.

18. Staff members who switch coverage between the Aetna and Blue Cross plans and who have met the annual deductible or any portion thereof under either of those plans during the first six months of the year may be credited with such deductible payment(s) under the new plan for the second six months of the year, under certain conditions. The deductible credit will not occur automatically and can be implemented only if the staff member takes the following actions:

(a) Formally requests the deductible credit on the special form designed for that purpose; and

(b) Attaches the original explanations of benefits attesting to the level of deductibles met for the staff member and/or each eligible covered dependant.

The deductible credit application form can be obtained by sending a request by e-mail to insurance-unhq@un.org. The completed form must be submitted to the Health and Life Insurance Section (not to Aetna or Blue Cross) together with the relevant explanations of benefits no later than 31 August 2013 in order to receive such deductible credit.

Coordination of benefits

19. The United Nations insurance programme does not reimburse the cost of services that have been or are expected to be reimbursed under another insurance, social security or similar arrangement. For those members covered by two or more plans, the United Nations insurance programme coordinates benefits to ensure that the member receives as much coverage as possible but not in excess of expenses incurred. Members covered under the United Nations insurance programme are expected to advise the insurance carriers when a claim can also be made against another insurer. Benefits are coordinated as follows:

(a) Aetna and Empire Blue Cross conduct coordination of benefits exercises as part of the administrative services they provide to the United Nations;

(b) Empire Blue Cross conducts its own exercises by mailing out annual questionnaires to members, and Aetna uses the services of the Rawlings Company to conduct its coordination of benefits exercises.

Plan participants are required to complete and return all questionnaires sent to them by insurance carriers.

Fraud and abuse

20. Fraud or abuse of the plan by any member (i.e. active staff member or retiree and their covered family members) will result in immediate recovery of monies and disciplinary measures in accordance with the Staff Regulations and Staff Rules of the United Nations and other administrative directives. Such measures may include the forfeiture or suspension of participation in any health insurance plan of the Organization or suspension from receiving any subsidy from the Organization.

21. Fraud or abuse of the plan by any provider will be handled according to the applicable procedures of the insurance carrier and may be referred to the local authorities. Members are highly encouraged to carefully review their explanation of benefits to ensure that only services received from their provider are billed and to report any questionable charges to the insurance carriers so that these can be investigated.

Eligibility and enrolment rules and procedures

22. All staff members holding appointments of three months or longer may enrol themselves and eligible family members in the United Nations insurance programme. In addition, staff members holding temporary appointments with one or more extensions that when taken cumulatively will amount to three months or more of continuous service can enrol themselves and eligible family members from the beginning of the contract that will meet the three-month minimum threshold.

23. Staff members holding temporary appointments of less than three months are eligible to enrol in the Vanbreda short-term medical insurance plan on an individual

basis. Information regarding the insurance programme for temporary appointments of less than three months can be obtained from the Health and Life Insurance Section. Staff members enrolled in the short-term medical insurance plan will be required to switch to one of the regular medical insurance plans upon extension of such temporary appointment beyond three months.

24. Post-retirement appointees who are covered under the United Nations plans in accordance with the after-service health insurance provisions may continue such coverage, except when they are re-employed by the United Nations, the United Nations Development Programme (UNDP) or the United Nations Children's Fund (UNICEF) and their service period requires re-entry into the United Nations Joint Staff Pension Fund as a contributing participant. The post-retirement appointee who returns to service and re-enters the Pension Fund as a contributing participant must discontinue his or her after-service health insurance coverage and enrol in the health plan as an active staff member. At that time the staff member may retain his or her level of coverage or change the level of coverage if he or she so desires. After-service health insurance coverage will resume upon separation from service and reapplication within 31 days of such separation, but at the level of coverage that existed on the initial after-service health insurance application. Failure to reapply within 31 days of separation will cause the post-retirement appointee to lose his or her eligibility for after-service health insurance.

25. For enrolment purposes, applicants will be required to present proof of eligibility from their respective personnel or administrative officers attesting to their current contractual status. Eligible family members may also be enrolled at this time, provided that evidence of the status (approved personnel action) of such family members is presented to the Health and Life Insurance Section. Interested staff members should carefully review the current status of their family's enrolment, both as to the continued eligibility of their children and/or the inclusion of those newly eligible or not presently covered.

26. "Eligible family members" referenced in the present circular do not include family members of temporary staff with appointments of less than three months or family members of occasional workers. The term "eligible family members" refers to a recognized spouse and one or more dependent children. The United Nations health insurance programme recognizes only one eligible spouse. A dependent child must be the natural-born or legally adopted child of the staff member or a stepchild reflected as a household member in the Integrated Management Information System (IMIS) of the United Nations, the Atlas system of UNDP or the SAP system of UNICEF in order to be eligible. A child is eligible to be covered under the programme until the end of the calendar year in which he or she attains the age of 25 years, provided that he or she is not married or employed full-time. Disabled children may be eligible for continued coverage after the age of 25 provided they are certified disabled by the Medical Services Division.

27. Staff members, particularly those who have no coverage under a United Nations plan or are covered through another family member, are strongly urged to obtain medical insurance coverage for themselves and their eligible family members during the annual campaign or after a qualifying event, especially since the high cost of medical care could result in financial hardship for individuals who fall ill and/or are injured and have no such coverage. Injury or illness is not a "qualifying" event for enrolment in the United Nations health insurance programme.

Staff member married to another staff member

28. In the case of a staff member married to another staff member, both staff members may elect to maintain their own individual insurance coverage at the "staff member only" coverage level. In the case of coverage at the two-person (i.e. "staff member plus spouse" or "staff member plus one dependant") or family level, such coverage must be carried by the higher-salaried staff member.

29. The determination of the higher-salaried staff member is based on the "medical net" salary of both staff members. "Medical net" salary is calculated as gross salary, less staff assessment, plus post adjustment, language allowance and non-resident allowance. In the case where both staff members in the same duty station belong to the same category and grade, the higher-salaried staff member will be the one who is at least four steps higher than the other; otherwise, either one may carry the two-person or family coverage.

30. The only exception to the policy above is in the case of a staff member on a temporary appointment of less than 364 days married to another staff member on a fixed-term, continuing or permanent appointment: the insurance coverage at the two-person or family level must be carried by the staff member whose appointment is not temporary.

31. It should also be noted that if one spouse retires from service with the Organization before the other spouse, the spouse who remains in active service must become the subscriber even if the retired spouse had been the subscriber up to the date of retirement and is eligible for after-service health insurance benefits following separation from service. The retiring staff member must nevertheless submit an application for after-service health insurance to the Health and Life Insurance Section in order to preserve his or her right to exercise the benefit in the future.

Enrolment between annual campaigns

32. Between annual campaigns, staff members and their eligible family members may be allowed to enrol in the Headquarters-administered medical and dental insurance plans only if at least one of the following "qualifying" events occurs and application for enrolment is made within 31 days of such occurrence:

(a) In respect of medical insurance coverage, upon receipt of an initial fixed-term or temporary appointment of at least three months' duration at Headquarters; and in the case of temporary appointees, upon achieving a threshold duration of continuous active employment at a minimum of half-time for at least three months;[1]

(b) In respect of dental insurance coverage, upon receipt of an initial fixed-term or temporary appointment of at least three months' duration at Headquarters;[1]

(c) Upon transfer of the staff member to a new duty station;[1]

(d) Upon return from special leave without pay, but only under the health insurance plan and coverage type in which the staff member was insured prior to taking leave (i.e. no opportunity to enrol eligible family members if they were not

[1] If coverage for eligible family members is desired, such enrolment must be done at the same time as the staff member's application even if the dependants have not arrived at the duty station.

covered prior to taking leave, with the exception of the events referred to in subparagraphs (e) and (f) below);

(e) Upon marriage, in the case of spouses, provided the staff member is currently enrolled;

(f) Upon birth or legal adoption, in the case of children, provided the staff member is currently enrolled;

(g) Upon presentation of proof of loss of coverage under a spouse's health insurance plan in accordance with paragraph 47;

(h) Upon the provision of evidence that the staff member was on mission or annual or sick leave for the entire duration of the annual campaign and submission of a completed application within 31 days of his or her return to the duty station.

33. Staff members and their eligible dependants may terminate their coverage under the medical and dental plans between annual campaigns only if one of the following "qualifying" events occurs and application for termination is made within 31 days of such occurrence:

(a) Upon divorce, in the case of a spouse;

(b) Upon the death of a covered dependant;

(c) Upon marriage or full-time employment of a covered child;

(d) Upon employment of a spouse with the United Nations Secretariat or a United Nations system organization on a non-temporary appointment at a higher grade and level and eligibility for medical insurance coverage.

34. In all the cases cited in the paragraphs above, the completed application for enrolment, re-enrolment or termination must be certified by the appropriate personnel or administrative officer and received by the Insurance and Disbursement Service within 31 days of the occurrence of the event giving rise to entitlement to enrol. Applications and enquiries with regard to changes relating to such events occurring between campaigns should be directed to the Health and Life Insurance Section as follows:

Health and Life Insurance Section
Office of Programme Planning, Budget and Accounts
Department of Management
United Nations
E-mail: insurance-unhq@un.org

Applications between enrolment campaigns based on any other circumstances or not received within 31 days of the event giving rise to eligibility will not be receivable by the Health and Life Insurance Section and will be returned. Staff members who, for any reason, are uncertain as to the continuity of any outside coverage are urged to consider enrolling in a United Nations scheme during the present campaign.

Staff on special leave without pay

35. Staff members granted special leave without pay are reminded that they may retain coverage for medical and dental insurance during such periods or may elect to discontinue such coverage for the period of the special leave, under the following conditions:

(a) **Insurance coverage maintained during special leave without pay**. If the staff member decides to retain coverage during the period of special leave without pay, the Health and Life Insurance Section must be informed directly by the staff member of his or her intention at least 31 days in advance of the commencement of the special leave, in person if at Headquarters, or in writing if stationed away from Headquarters. At that time, the Health and Life Insurance Section will require evidence of the approval of the special leave, together with payment covering the full amount of the cost of the coverage(s) retained (i.e. both the staff member's contribution and the Organization's share, since no subsidy is payable during such leave). Staff members may be allowed to switch to a health insurance plan that is more appropriate to where he or she will reside during the period of special leave. However, staff members enrolled in the Vanbreda plan before going on special leave and planning to reside in the United States during the period of special leave must enrol in a United States plan;

(b) **Insurance dropped while on special leave without pay**. Should a staff member decide not to retain insurance coverage(s) while on special leave without pay, the staff member must notify the Health and Life Insurance Section upon commencement of the special leave;

(c) **Re-enrolment upon return to duty following special leave without pay**. Regardless of whether a staff member has decided to retain or drop insurance coverage(s) during a period of special leave without pay, it is essential that he or she re-enrol in the plan(s) with the Health and Life Insurance Section upon return to duty, in person (if at Headquarters) or by e-mail with a completed and signed application form. This must be done within 31 days of return to duty. Failure to do so will mean that the staff member will be unable to resume participation in the insurance plan(s) until the next enrolment campaign in the month of June. Staff members will be allowed to re-enrol only under the health insurance plan and coverage type in which he or she was insured prior to taking leave, in accordance with paragraph 32 (d) above.

Special provisions for the Vanbreda plan

36. The Vanbreda programme covers current and former staff members who reside in all parts of the world, except the United States. Current and former staff members and their dependants who reside in the United States are not eligible for Vanbreda coverage.

37. The sole exception to this exclusion arises in the case of a dependent child attending school or university in the United States who is required by the educational institution to enrol in its health insurance plan. In this case, the student's health insurance plan at the school or university will be primary and the Vanbreda coverage will be secondary. Staff members who do not meet the requirements stated above will be required to switch their insurance to a United States-based plan. It should be noted that the United States dental plan is separate from the medical plans. If dental coverage is desired, the dental portion of the group medical and dental insurance application form should be properly filled out.

38. Staff members covered under the Vanbreda worldwide plan should not seek medical care in the United States because the plan does not offer adequate medical protection owing to the annual reimbursement limit of $250,000 and the high cost of medical care in the United States that is not reflected in Vanbreda's premium.

Medical treatment obtained in the United States will be subject to all restrictions and limitations of the Vanbreda plan, and staff members will be responsible for the payment of all amounts that exceed benefit limits and annual maximums. Prior notification is mandatory and will allow Vanbreda International to propose alternatives and negotiate significant discounts. Failure to receive prior approval from Vanbreda for care in the United States will be subject to penalty. Participants who seek medical care in the United States on a regular basis will be required to switch to a United States-based plan.

Participant's address for insurance purposes

39. It is the responsibility of each staff member to ensure that his or her correct, up-to-date mailing address is stored in his or her organization's system (i.e. IMIS for the United Nations, Atlas for UNDP and SAP for UNICEF). As addresses are a part of a staff member's personnel profile, staff members should contact their personnel or executive offices in order to provide or update their address. Please be aware that the insurance carriers only recognize addresses that are electronically transmitted to them by the United Nations from the above-mentioned systems. It is also essential that the address bear the United States postal abbreviation for states (e.g. New York and New Jersey must be designated as NY and NJ, respectively). Zip codes must also be part of the address. Incomplete address information will result in the insurance carriers rejecting the data transmission, as well as in misdirected mail and failure to receive important correspondence, identification cards or even benefit cheques.

Effective commencement and termination date of health insurance coverage

40. Provided that the application is made within the prescribed 31-day time frame, coverage for a staff member newly enrolled in a health insurance plan commences on the first day of a qualifying contract or the first of the following month. When a contract terminates before the last day of a month, coverage will remain in place until the last day of that month. As mentioned previously, premiums are not prorated.

41. Any expenditure, including those related to ongoing treatment, incurred after the expiry of coverage will not be covered by the health insurance programme.

Movement between organizations, breaks in appointment and movement between payrolling offices

42. It is important to note that coverage is terminated automatically but not restored automatically for staff members who:

(a) Are separated from service;

(b) Transfer between organizations, e.g. United Nations, UNDP and UNICEF;

(c) Are reappointed following any or no break in employment, or following a change in employment contract/appointment;

(d) Transfer to a different payrolling office (i.e. New York, Geneva, Vienna, Nairobi, the regional commissions and the international tribunals).

43. Most individuals whose contracts end do, in fact, leave the United Nations common system. However, many insured staff members are reappointed or transferred between the United Nations, UNDP and UNICEF, for example, or between different United Nations payrolling offices. Those staff members must reapply for health insurance coverage as soon as a personnel action has been generated by their employing organization. Such reapplication for health insurance coverage must be made within 31 days of the effective date of the reappointment or transfer. Strict attention to this requirement is necessary to ensure continuity of health insurance coverage because, as noted, separation from an organization and transfers between payrolling offices result in the automatic termination of insurance coverage at the end of the month. Staff members who transfer between organizations should also ensure that the receiving organization establishes the staff member's household members and mailing address in its database so that coverage can be reinstated under the receiving organization.

Cessation of coverage of the staff member and/or family members

44. Staff members are required to immediately notify the Health and Life Insurance Section of changes in the staff member's family that result in a family member ceasing to be eligible, for example a spouse upon divorce or a child marrying or taking up full-time employment. Other than with respect to children reaching the age of 25, the responsibility for initiating the resulting change in coverage (e.g. from "staff member and spouse" to "staff member only" or from "family" to "staff member and spouse") rests with the staff member.

45. Staff members wishing to discontinue their coverage, or that of an eligible family member, must communicate the instruction to the Health and Life Insurance Section in writing within 31 days of the qualifying event even prior to the approval of the related personnel action. It is in the interest of staff members to notify the Health and Life Insurance Section promptly whenever changes in coverage occur in order to benefit from any reduction in premium contribution that may result. Changes will be implemented on the first of the month following receipt of an approved written notification. No retroactive refund of contribution can be made as a result of the staff member's failure to provide timely notification of any change to the Health and Life Insurance Section.

46. In the case of disabled children over the age of 25, eligibility for health insurance coverage shall cease as a result of emancipation, marriage, full-time employment or cessation of a pension or compensation benefit, whichever comes first.

Insurance enrolment resulting from loss of employment of spouse

47. Loss of coverage under a spouse's health insurance plan owing to the spouse's loss of employment beyond his or her control is considered a qualifying event for the purpose of enrolment in a United Nations Headquarters programme, provided that the staff member is otherwise eligible to participate in the programme. Application for enrolment in a United Nations plan under these circumstances must be made within 31 days of the qualifying event and must be accompanied by an official letter from the spouse's employer certifying the termination of employment and its effective date and the end date and type of insurance coverage.

After-service health insurance

48. Staff members are reminded that, among the eligibility requirements for after-service health insurance coverage, the applicant must be enrolled in a United Nations scheme at the time of separation from service. Enrolment in the after-service health insurance programme is not automatic. Application for enrolment must be made within 31 days prior to, or immediately following, the date of separation. Full details on the eligibility requirements and administrative procedures relating to after-service health insurance coverage are set out in administrative instruction ST/AI/2007/3 on after-service health insurance.

49. In the case of death of a staff member, information on continuation of coverage for surviving spouse and/or dependent children can be found in administrative instruction ST/AI/2007/3.

50. Beginning 1 January 2011, the United Nations Headquarters required all former staff members and dependants (including surviving spouses and eligible dependent children) who are enrolled as participants in the after-service health insurance and who qualify for participation in Medicare Part B to enrol in the United States Medicare Part B programme. Those retirees who are eligible to enrol in Medicare Part B but choose not to enrol will have their claims adjudicated as if they were enrolled. Full details on the requirements of the Medicare Part B programme are set out in the information circular ST/IC/2011/3.

Conversion privilege

51. A "conversion privilege" is part of the United Nations group insurance programme. This privilege allows staff members (subscribers) who cease employment with the United Nations and do not qualify for after-service health insurance benefits to arrange for medical coverage under an individual contract by contacting the insurance companies directly to purchase private insurance. This provision applies to the Aetna, Empire Blue Cross, HIP and Vanbreda medical plans. The Cigna dental plan does not have a conversion option.

52. The conversion privilege means that the insurer cannot refuse to insure an applicant and that no certification of medical eligibility is required. The conversion privilege applies to staff members, retirees and/or their dependants who were covered by a health insurance plan administered by United Nations Headquarters. However, the conversion privilege does not mean that the same insurance premium rates or schedule of benefits in effect for the United Nations group policy will be offered in respect of individual insurance contracts. The plans offered by the insurance carriers are not United Nations group plans; benefits and premiums will therefore be different. It should also be noted that the Health and Life Insurance Section does not handle or administer any of the insurance carriers' private plans. Moreover, the conversion privilege for participants enrolled in a United States-based insurance plan may be exercised only by separating staff who continue to reside in the United States, specifically in states where the insurance carriers sell individual policies, as the insurers cannot write individual policies for persons residing in certain states or abroad.

53. Staff members may apply for a policy of individual coverage under the conversion privilege for themselves only or for themselves and their covered eligible dependants. Moreover, eligible dependants who are members of the United

Nations insurance programme may also apply on their own for a policy under the conversion privilege. Staff members must contact the applicable insurance carrier as soon as coverage is terminated (normally within 31 days of such termination). Each carrier has its own procedures for exercising the conversion privilege.

54. Details on purchasing individual policies under Aetna, Empire Blue Cross, HIP and Vanbreda should be obtained directly from the insurance carriers.

Claim filing time limits

55. Subscribers should note that claims for reimbursement for out-of-network utilization must be received by the plans' administrators no later than two years from the date on which the health expense was incurred. Claims received by Empire Blue Cross, Aetna, Cigna or Vanbreda later than two years after the date on which the expense was incurred will not be eligible for reimbursement.

Claim payments issued by cheque

56. Subscribers who receive reimbursements by cheque are responsible for the timely cashing of those cheques. Neither the insurance carriers nor the Health and Life Insurance Section will reprocess uncashed cheques over two years old.

Claims and benefit enquiries and disputes

57. Claims questions must be addressed directly with the insurance company concerned. In the case of disputed claims, the staff member must exhaust the appeal process with the insurance company before requesting assistance from the Health and Life Insurance Section. The process is indicated in the explanation of benefits or denial letter mailed to the member by the insurance company and the applicable summary plan description documents. The addresses and relevant telephone numbers of the insurance companies are listed in annex X. The staff members of the Health and Life Insurance Section are available to advise staff members on problematic claims issues and administrative matters concerning participation in the Headquarters insurance plans once the staff members have exhausted their various options with the insurance carriers.

58. Staff members are reminded that information about the plans may be found in the plan outlines in the annexes to the present information circular and the summary plan descriptions located on the website of the Health and Life Insurance Section, www.un.org/insurance. For more detailed descriptions of the benefits in the Aetna, Empire Blue Cross, HIP and Cigna programmes, including most exclusions and limitations, staff members should contact the insurance carriers. In the event of a claim dispute, the resolution of such dispute will be guided by the terms and conditions of the policy or contract in question. The final decision rests with the insurance company (in the case of HIP) or the plan administrator (in the case of Aetna, Empire Blue Cross, Cigna and Vanbreda), and not with the United Nations.

Websites of the Health and Life Insurance Section and the insurance providers

59. The website of the Health and Life Insurance Section can be accessed at www.un.org/insurance. Within the website, information can be found about the United Nations programmes, as well as relevant forms and, through weblinks, lists of health-care service providers that participate in the various programmes. Detailed

descriptions of the Aetna, Empire Blue Cross, Cigna, Vanbreda and ActiveHealth programmes are also posted on the website.

60. Each of the insurance companies in the United Nations health insurance programme has its own website providing a wide range of information about the plan, such as:

(a) Health-care providers;

(b) Physicians;

(c) Participating hospitals;

(d) Pharmacies;

(e) Prosthetics, orthotics, durable medical equipment and medical supplies vendors;

(f) Dentists;

(g) Health education;

(h) Covered services;

(i) Replacement insurance cards;

(j) Explanations of benefits or claims processed.

Please refer to the provider contact directory contained in annex X, which provides the Internet address of each carrier, as well as related instructions.

Annex I

Premiums and contribution rates

Headquarters-administered medical and dental insurance schedule of monthly premiums[a] and contribution rates[b]

(Effective 1 July 2013)

(Premium rates in United States dollars)

	Aetna Open Choice PPO POS II		*Empire Blue Cross PPO*		*HIP*[c]		*Cigna Dental PPO with Aetna, Empire Blue Cross or HIP*		*Cigna Dental PPO alone*
Type of coverage	*2012 rates*	*2013 rates*	*2012 rates*	*2013 rates*	*2012 rates*	*2013 rates*	*2012 rates*	*2013 rates*	*2013 rates*
Staff member only									
Premium rate	915.51	945.54	609.81	638.96	726.03	766.22	61.82	63.40	63.40
Contribution rate (percentage)	4.96	5.00	3.39	3.43	4.42	4.66	0.32	0.32	0.45
Staff member and one child									
Premium rate	1 827.09	1 887.02	1 216.66	1 274.82	1 325.71	1 399.10	123.65	126.80	126.80
Contribution rate (percentage)	8.66	8.73	6.00	6.08	6.76	7.13	0.56	0.56	0.79
Staff member and spouse									
Premium rate	1 827.09	1 887.02	1 216.66	1 274.82	1 325.71	1 399.10	123.65	126.80	126.80
Contribution rate (percentage)	8.66	8.73	6.00	6.08	6.76	7.13	0.56	0.56	0.79
Staff member and two or more eligible family members									
Premium rate	2 286.39	2 361.38	1 766.44	1 850.88	2 110.56	2 227.41	199.65	204.74	204.74
Contribution rate (percentage)	9.67	9.75	7.65	7.75	9.48	10.01	0.86	0.86	1.35

[a] The cost of the medical/dental insurance plans at Headquarters is shared between the participants and the Organization.

[b] Staff members may determine their exact contribution by multiplying their "medical net" salary by the applicable contribution rate above. "Medical net" salary for insurance contribution purposes is calculated as gross salary, less staff assessment, plus language allowance, non-resident's allowance and post adjustment. Actual contributions are capped at 85 per cent of the corresponding premium.

[c] Effective 1 July 2013, the HIP Health Plan of New York is closed to new subscribers (i.e. staff members or retirees). Subscribers who are currently covered may remain in the plan, and any changes related to eligible household members will be accepted. However, a current subscriber who switches to another United States plan during the 2013 annual campaign will not be allowed to return to the HIP plan in future annual campaigns.

Vanbreda health insurance schedule of monthly premiums[a] and contribution rates[b]

(Effective 1 July 2013)

	Monthly premium (United States dollars)		*Contribution rate (percentage)*	
	Effective		*Effective*	
Type of coverage	*January 2012*	*July 2013*	*January 2012*	*July 2013*
Rate group 1[c]				
Staff member only	134	147	1.51	1.51
Staff member and one family member	286	314	2.33	2.33
Staff member and two or more eligible family members	472	518	3.67	3.67
Rate group 2[d]				
Staff member only	230	253	2.31	2.31
Staff member and one family member	485	533	3.73	3.73
Staff member and two or more eligible family members	801	880	5.86	5.86
Rate group 3[e]				
Staff member only	221	243	2.41	2.41
Staff member and one family member	466	512	3.88	3.88
Staff member and two or more eligible family members	768	844	6.11	6.11

[a] The cost is shared between the participants and the Organization.

[b] Staff members may determine their exact contribution by multiplying their "medical net" salary by the applicable contribution rate above. "Medical net" salary is calculated as gross salary, less staff assessment, plus language allowance, non-resident's allowance, post adjustment or the variable element of monthly subsistence allowance, as applicable.

[c] Rate group 1 includes all locations outside the United States of America other than those listed under rate groups 2 and 3.

[d] Rate group 2 includes Chile and Mexico.

[e] Rate group 3 includes Andorra, Austria, Belgium, Cyprus, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Luxembourg, Malta, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, Turkey (European portion) and United Kingdom of Great Britain and Northern Ireland.

Annex II

United States-based medical benefits: plan comparison chart[a]

	In-network			*Out-of-network*	
Benefits	*HIP Health Plan of New York (in-network only)*	*Aetna*	*Blue Cross*	*Aetna*	*Blue Cross*
Annual deductible	$0.00	$0.00	$0.00	Individual: $250 Family: $750	Individual: $250 Family: $750
Insurance coverage	100%	100%	100%	80% after deductible	80% after deductible
Annual out-of-pocket maximum	Not applicable	Not applicable	Not applicable	Individual: $1,250 Family: $3,750 (with deductible)	Individual: $1,250 Family: $3750 (with deductible)
Lifetime maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Claim submission	Provider files	Provider files	Provider files	You file	You file
Hospital benefits					
Inpatient Pre-registration required	100%	100%	100%	100%	United States: 80% after deductible International: 100%
Outpatient	100%	100%	100%	100%	United States: 80% after deductible International: 100%
Emergency room (initial visit)	100% accidental injury; sudden and serious medical condition	100% after $50 co-pay (waived if admitted within 24 hours)	100% after $50 co-pay (waived if admitted within 24 hours)	100% after $50 co-pay (waived if admitted within 24 hours)	100% after $50 co-pay (waived if admitted within 24 hours)
Emergency room visit (for non-emergency care)	100% Urgent care covered in the United States	80%	Not covered	80% after deductible	Not covered

	In-network			*Out-of-network*	
Benefits	*HIP Health Plan of New York (in-network only)*	*Aetna*	*Blue Cross*	*Aetna*	*Blue Cross*
Medical benefits					
Office/home visits	100%	100% after $15/$20 primary care physician/ specialist co-pay	100% after $15/$20 primary care physician/ specialist co-pay	80% after deductible	80% after deductible
Routine physical	100% once every 12 months	100% after $15 co-pay once every 12 months	100% after $15 co-pay once every 12 months	80% after deductible once every 12 months	80% after deductible once every 12 months
Surgery	100%	100%	100%	80% after deductible	80% after deductible
Prescription drugs					
Pharmacy	$5.00 for generic/brand per 30-day supply	20% co-pay up to $20 per 30-day supply	20% co-pay up to $20 per 30-day supply	United States: 60% after deductible International: 80% after deductible	United States: 60% after deductible International: 80% after deductible
Mail order	$2.50 for generic/brand per 30-day supply	100% after $15 co-pay per 90-day supply	100% after $15 co-pay per 90-day supply	Not applicable	Not applicable
Behavioural health-care benefits (must be pre-certified; benefit maximum for in-network and out-of-network combined)					
Inpatient mental health care	100%	100%	100%	100% after	80% after deductible
Outpatient mental health care	100%	100%	100%	80% after deductible	80% after deductible
Inpatient alcohol and substance abuse care	100%	100%	100%	100% after	80% after deductible
Outpatient alcohol and substance abuse care	100%	100%	100%	80% after deductible	80% after deductible

	In-network			*Out-of-network*	
Benefits	*HIP Health Plan of New York (in-network only)*	*Aetna*	*Blue Cross*	*Aetna*	*Blue Cross*
Vision care					
Eye exam	100% 1 exam every 12 months	100% after $20 co-pay 1 exam every 12 months	100% after $15 co-pay 1 exam every 12 months	80% 1 exam every 12 months	$40.00 allowance 1 exam every 12 months
Frames and optical lenses	$45 every 24 months for frames and lenses from select group	Save up to 65% at participating centres	$130 allowance then 20% discount on remaining balance for frames, $10 co-pay for lenses	80% up to $100 per year	$45 for frames $25/pair single vision $40/pair bifocal lenses $55/pair trifocal lenses (amounts listed are allowances provided by insurance)
Other benefits					
Physical and other inpatient therapy	100% 90 visits	100%	100% 60 visits	80%	80% after deductible 60 visits
Physical and other outpatient therapy	100% 90 visits	100%	100% after $20 co-pay 60 visits	80% after deductible	80% after deductible 60 visits
Durable medical equipment	100%	100%	100%	80%	Not covered

[a] A more detailed summary of benefits for each plan is contained in the succeeding annexes and applicable summary plan descriptions.

Annex III

Empire Blue Cross PPO

Plan outline

The Empire Blue Cross PPO plan provides worldwide coverage for hospitalization and surgical, medical, vision and prescription drug expenses. Under this plan, medically necessary treatment for a covered illness or injury may be obtained at a hospital or from a physician of one's own choosing, whether an in-network or out-of-network provider.

This annex will provide a high-level summary chart of the plan. For detailed information staff members must review the Empire Blue Cross PPO Plan Description document available at the Health and Life Insurance Section website, www.un.org/insurance.

In addition, members of the Empire Blue Cross plan have access to FrontierMEDEX and ActiveHealth as part of participation in this plan.

Coverage when travelling or living outside of the United States is handled by BlueCard Worldwide. Details can be found in the Empire Blue Cross PPO Plan Description document available at the Health and Life Insurance Section website, www.un.org/insurance.

Empire Blue Cross PPO summary of benefits

Benefits	*In-network*[a]	*Out-of-network*
Annual deductible		
Individual	$0	$250
Family	$0	$750
Insurance coverage (percentage at which the plan pays benefits)	100%	80%
Annual out-of-pocket maximum		
Individual	$0	$1,250
Family	$0	$3,750
		(includes annual deductible; network and prescription drug co-pays do not count towards the out-of-pocket limit)
Lifetime maximum	Unlimited	
Dependent children	Covered to end of calendar year in which child reaches age 25	
Claim submission	Provider files claims	You file claims

Benefits	*In-network*[a]	*Out-of-network*
Hospital services and related care coverage		
Inpatient[b]		
– Unlimited days — semi-private room and board – Hospital-provided services – Routine nursery care	100%	80% after deductible within the United States 100% outside the United States
Outpatient		
– Surgery and ambulatory surgery[b] – Pre-surgical testing (performed within 7 days of scheduled surgery) – Blood – Chemotherapy and radiation therapy – Mammography screening and cervical cancer screening	100%	80% after deductible within the United States 100% outside the United States
Mandatory pre-registration[b] **(1-800-982-8089)** Refer to "*When to call the Medical Management Programme*" above	Pre-registrations are your responsibility	Pre-registrations are your responsibility
(For emergency admission, call within 48 hours or next business day if admitted on weekend)		
Hospital emergency room[c] **(initial visit)**		
– Accidental injury – Sudden and serious medical condition	100% including physician's charges after $50 co-pay (waived if admitted within 24 hours)	100% including physician's charges after $50 co-pay (waived if admitted within 24 hours)
Emergency room visit for non-emergency care is not covered		
Ambulance	100% up to the allowed amount	
Air ambulance (to nearest acute care hospital for emergency inpatient admissions)	100%	
Home health care[b,d]		
– Up to 200 visits per calendar year – Home infusion therapy	100% 100%	– 80% within the United States (deductible does not apply) – 100% outside the United States – Covered in-network only

Benefits	*In-network*[a]	*Out-of-network*
Outpatient kidney dialysis		
Home, hospital-based or free-standing facility treatment	100%	80% after deductible
Skilled nursing facility[b]		
Up to 120 days per calendar year	100%	In-network only within the United States 80% after deductible outside the United States
Hospice[b]		
Up to 210 days per lifetime	100%	In-network only
Physician services and other medical benefits (excluding behavioural health and substance abuse care)		
Office/home visits/office consultations	100% after $15/$20 primary care physician/specialist co-pay	80% after deductible
Surgery	100%	80% after deductible
Surgical assistant[e]	100%	80% after deductible
Anaesthesia[f]	100%	80% after deductible
Inpatient visits/consultations	100%	80% after deductible
Maternity care	100% after initial visit	80% after deductible
Diagnostic X-rays	100%	80% after deductible
Lab tests	100%	80% after deductible
Chemotherapy and radiation therapy Hospital outpatient or physician's office	100%	80% after deductible
MRIs/MRAs, PET/CAT scans and nuclear cardiology scans[b]	100%	80% after deductible
Cardiac rehabilitation[b]	100% after $20 specialist co-pay	80% after deductible
Second surgical opinion[g]	100% after $20 specialist co-pay	80% after deductible
Second Medical Opinion for Cancer Diagnosis	100% after $20 specialist co-pay	80% after deductible[h]
Allergy testing and allergy treatment	100% after $20 specialist co-pay per office visit for testing 100% for treatment visits	80% after deductible
Prosthetic, orthotics, durable medical equipment[i]	100%	In-network only

Benefits	*In-network*[c]	*Out-of-network*
Medical supplies	100%	100% up to the allowed amount
Preventive care		
Annual physical exam	100% after $15 co-pay	80% after deductible
Diagnostic screening tests	100%	80% after deductible
Prostate specific antigen (PSA) test	100%	80% after deductible
Well-woman care	100% after $15 co-pay	80% after deductible
Mammography screening	100%	80% after deductible
Well-child care (including recommended immunizations)[d]		
– Under 1 year of age: 7 visits – 1-4 years old: 7 visits – 5-11 years old: 7 visits – 12-17 years old: 6 visits – 18 years-19th birthday: 2 visits	100%	100%
Physical therapy and other skilled therapies		
Physical therapy[b]		
– 60 inpatient visits, and	100%	80% after deductible
– 60 visits combined in home, office or outpatient facility	100% after $20 specialist co-pay	80% after deductible
Occupational, speech, vision[b]		
30 visits combined in home, office or outpatient facility	100% after $20 specialist co-pay	80% after deductible
Behavioural health and substance abuse services		
Inpatient mental health care[j]	100%	80% after deductible
Outpatient mental health care[j]	100%	80% after deductible
Inpatient alcohol and substance abuse[j]	100%	80% after deductible
Outpatient alcohol and substance abuse[j]	100%	80% after deductible

Benefits	*In-network*[a]	*Out-of-network*
Prescription drug benefits		
Card Programme 30-day supply (800)-373-6770	20% co-pay with $5 minimum and up to a maximum of $20 per prescription	Within the United States: 60% after deductible Outside the United States: 80% after deductible (claim form must be filed for reimbursement) The co-insurance will not count towards $1,250/$3,750 out-of-pocket limit
Mail order (Express Scripts) — Fax: (877) 426-1097	100% after $15 co-pay for up to a 90-day supply from participating mail order vendor	

Prescriptions for Mail Order Programme — when a brand-name drug is dispensed and an equivalent generic is available, the member will pay the $15 co-pay plus the difference in cost between the generic and the brand-name drug unless the doctor specifies the brand-name drug by writing "DAW" or "Dispense as Written" on the prescription. In that event, you pay the normal $15 co-pay only.

Vision Care Programme		
Blue View Vision (866) 723-0515		
(Eye Med in New Jersey)		
Routine eye exam (once every 12 months)	$15 co-pay	$40 allowance
Eyeglass frames (once every 12 months)	$130 allowance, then 20% off balance	$45 allowance
Eyeglass lenses		
Single	$10 co-pay, then covered in full	$25 allowance
Bifocal	$10 co-pay, then covered in full	$40 allowance
Trifocal	$10 co-pay, then covered in full	$55 allowance
Eyeglass lens upgrades		
UV coating	$15 member cost	$0
Tint (solid and gradient)	$15 member cost	$0
Standard scratch-resistance	$15 member cost	$0
Standard polycarbonate	$40 member cost	$0
Standard progressive	$65 member cost	$0
Standard anti-reflective coating	$45 member cost	$0
Other add-ons and services	20% off retail price	$0

Benefits	*In-network*[a]	*Out-of-network*
Contact lenses		
Elective conventional	$130 allowance, then 15% off balance	$105 allowance
Elective disposable	$130 allowance	$105 allowance
Non-elective	Covered in full	$210 allowance
Contact lens fitting		
Standard fitting	Up to $55	$0
Premium fitting	10% off retail price	$0

In addition, Blue View Vision gives members 40% off an additional pair of complete eyeglasses, 15% of the retail price of conventional contact lenses, and 20% off the retail price of eyewear accessories (some non-prescription sunglasses, lens cleaning supplies, contact lens solutions, and eyeglass cases).

Other health care		
Acupuncture	100% after $20 co-pay	80% after deductible
Chiropractic care		
$1,000 annual limit on combined in- and out-of-network benefits	100% after $20 co-pay	80% after deductible
Hearing exam (every 3 years)	100% after $20 specialist co-pay	80% after deductible
Hearing appliance	Not covered	Not covered

[a] In-network services (except mental health or alcohol/substance abuse) are those from a provider that participates with Empire or another Blue Cross Blue Shield Plan through the BlueCard Programme, or a participating provider with another Blue Cross Blue Shield Plan that does not have a PPO network and does accept a negotiated rate arrangement as payment-in-full.
[b] Medical Management Programme must pre-approve or benefits will be reduced 50 per cent up to $2,500.
[c] If admitted, Medical Management must be called within 24 hours or as soon as reasonably possible.
[d] Combined maximum visits for in-network and out-of-network services.
[e] If the surgical assistant is an out-of-network provider and is assisting a participating surgeon, payment will be made in full.
[f] If the anaesthesiologist is an out-of-network provider but is affiliated with a participating hospital, payment will be made in full.
[g] Charges to members do not apply if the second surgical opinion is arranged through the Medical Management Programme.
[h] If arranged through the Medical Management Programme, services provided by an out-of-network specialist will be covered as if the services had been in-network (i.e. subject to the in-network co-payment).
[i] In-network vendor must call Medical Management to pre-certify.
[j] Empire Behavioural Health Services must pre-approve or benefits will be reduced 50 per cent up to $2,500. Out-of-network mental health care does not require precertification; however, outpatient alcohol and substance abuse visits must be pre-certified. In-network mental health services are those from providers that participate with Empire Behavioural Health Services.

Annex IV

Aetna Open Choice PPO/POS II

Plan outline

The Aetna Open Choice PPO/Aetna Choice POS II offers worldwide coverage for hospitalization and surgical, medical, vision and prescription drug expenses. Under this plan, medically necessary treatment for a covered illness or injury may be obtained at a hospital or from a physician of one's own choosing, whether an in-network or out-of-network provider.

This annex will provide a high-level summary chart of the plan. For detailed information staff members must review the Aetna Open Choice PPO/POS II Plan Description document available at www.un.org/insurance.

In addition, members of the Aetna plan have access to FrontierMEDEX and ActiveHealth as part of participation in this plan.

Aetna Open Choice PPO/POS II summary of benefits

Benefits	*In-network*	*Out-of-network*
Annual deductible		
Individual	$0	$250
Family	$0	$750
Insurance coverage (% at which the plan pays benefits)	100% except where noted	100% Hospital; 80% all other, except where noted
Annual out-of-pocket maximum		
Individual	$0	$1,250
Family	$0	$3,750
		(includes annual deductible; network and prescription drug co-pays do not count towards the out-of-pocket limit)
Lifetime maximum	Unlimited	Unlimited
Dependent children	Covered to end of calendar year in which child reaches age 25	
Claim submission	Provider files claims	You file claims
Hospital services and related care coverage		
Inpatient coverage	100%	
Outpatient coverage	100%	
Mandatory pre-registration (1-800-333-4432) Applies to inpatient hospital, skilled nursing facility, home health care, hospice care and private duty nursing care	Provider is responsible	You or provider are responsible
(For emergency admission, call within 48 hours or next business day if admitted on weekend)		
Hospital emergency room Based on symptoms, i.e. constituting a perceived life-threatening situation	100% including physician's charges after $50 co-pay (waived if admitted within 24 hours)	100% including physician's charges after $50 co-pay (waived if admitted within 24 hours)
Hospital emergency room For non-emergency care (examples of conditions: skin rash, earache, bronchitis, etc.)	80%	80% after deductible
Ambulance [There are no network providers for these services at the present time.]	100%	

Benefits	*In-network*	*Out-of-network*
Skilled nursing facility	100% Up to 365 days per year for restorative care as determined by medical necessity.	
Private duty nursing (in-home only)	100% subject to yearly limits of $5,000 and 70 "shifts" as well as $10,000 lifetime. Must be determined to be medically necessary and supported by a doctor's prescription/medical report. Precertification is strongly recommended.	
Home health care Up to 200 visits per year	100% Must be determined to be medically necessary and supported by a doctor's prescription/medical report. Precertification is strongly recommended.	
Hospice (210 days)	100%, deductible does not apply.	
Plus 5 days bereavement counselling		
Physician services		
Office visits For treatment of illness or injury (non-surgical)	100% after $15/$20 primary care physician/specialist co-pay	80% after deductible
Maternity (includes voluntary sterilization and voluntary abortion, see Family planning)	100% after $15 co-pay	80% after deductible
Physician in-hospital services	100%	80% after deductible
Other in-hospital physician services (e.g. attending/independent physician who does not bill through hospital)	100%	80% after deductible
Surgery (in hospital or office)	100%	80% after deductible
Second surgical opinion	100%	100% after deductible
Anaesthesia	100% (if participating hospital)	80% after deductible
Allergy testing and treatment (given by a physician)	100% after $20 specialist co-pay	80% after deductible
Allergy injections (not given by a physician)	100%	80% after deductible
Preventive care		
Routine physicals and immunizations – Children age 7+ and adults: one routine exam every 12 months	100% after $15 co-pay	80% after deductible

Benefits	*In-network*	*Out-of-network*
Well-child care and immunizations Well-child care to age 7: – 6 visits per year age 0 to 1 year – 2 visits per year age 1 to 2 years – 1 visit per year age 2 to 7 years	100%	
Routine ob/gyn exam One routine exam per calendar year including one Pap smear	100% after $15 co-pay	80% after deductible
Family planning		
– Office visits including tests and counselling	100% after $20 specialist co-pay	80% after deductible
– Surgical sterilization procedures for vasectomy/tubal ligation (excludes reversals)	100%	80% (deductible waived)
Infertility treatment		
– Office visits including testing and counselling	100% after $20 specialist co-pay	80% after deductible
– Limited to procedures for correction of infertility including artificial insemination (but excluding in-vitro fertilization, G.I.F.T., Z.I.F.T., etc.). Limited to 6 treatments per lifetime.	100%	80% after deductible
Routine mammogram (no age limit)	100%	80% after deductible 100% if performed on an inpatient basis or in the outpatient department of a hospital
Annual urological exam by urologist	100%	80% after deductible
Behavioural health and substance abuse services		
Mental health inpatient services (1-800-424-1601)	100%	100% after deductible
Inpatient coverage		
These services are provided by Aetna Behavioural Health. Pre-registration of inpatient confinements is required. For in-network services, the network provider is responsible for pre-registration. For non-network inpatient services, either the physician or the participant must pre-register the confinement.		
Outpatient coverage	100%	80% after deductible
For out-of-network outpatient behavioural health and substance abuse benefits the patient co-insurance does not count towards meeting the annual out-of-pocket limits.		
Crisis intervention	100%	80% after deductible

Benefits	*In-network*	*Out-of-network*
Alcohol/drug abuse		
Inpatient coverage	100%	100% after deductible
Outpatient coverage	100%	80% after deductible
Prescription drug benefits		
Aetna Retail Rx (1-800-784-3991) **Aetna International Retail Rx (1-800-231-7729)** **Retail means regular 30-day supplies**	20% co-pay with minimum of $5 and up to a maximum of $20 per prescription	Within the United States: 60% after deductible Outside the United States: 80% after deductible The co-insurance will not count towards $1,250/$3,750 out-of-pocket limit
Aetna Mail Order Rx (1-866-612-3862) **Aetna International Mail Order Rx (1-800-231-7729)** **Mail order means 90-day supply**	100% after $15 co-pay for up to a 90-day supply from participating mail order vendor	
Prescriptions for Mail Order Programme — when a brand-name drug is dispensed and an equivalent generic is available, the member will pay the $15 co-pay plus the difference in cost between the generic and the brand-name drug unless the doctor specifies the brand-name drug by writing "DAW" or "Dispense as Written" on the prescription. In that event, you pay the normal $15 co-pay only.		
Vision and hearing care		
Eye exam (once every 12 months)	100%	80%, deductible does not apply
Optical lenses (including contact lenses once every 12 months)	$100 maximum for any two lenses and frames purchased in a 12-month period.	
Aetna Vision Discount Programme (1-800-793-8616) **Discount information for laser surgery (1-800-422-6600)**	Save up to 65% on frames, up to 50% on lenses, and about 20% on contact lenses at participating EyeMed Centres. Discounts available for laser surgery.	
Hearing exam Evaluation and audiometric exam	100% after $20 co-pay (one exam every three years; exam must be performed by otolaryngologist or state-certified audiologist)	80% after deductible (one exam, limited to $100 reimbursement every three years; exam must be performed by otolaryngologist or state-certified audiologist)
Hearing device **[There are no network providers for these services at the present time.]**	80%, deductible does not apply; $750 maximum benefit, one hearing aid per ear every three years.	
Other health care		
Physical and occupational therapy	100%	80% after deductible

Benefits	*In-network*	*Out-of-network*
Laboratory tests, diagnostic X-rays	100%	80% after deductible
Speech therapy	80% after deductible for out-of-network services (where services are rendered by a participating provider, 100% reimbursement applies after $20 co-pay)	
Outpatient Diabetic Self-Management Education Programme	80%, deductible does not apply [If services are rendered in a hospital, 100% reimbursement applies with no co-pay. If rendered in a network doctor's office, 100% reimbursement with $20 specialist co-pay applies]	
Durable medical equipment	80%, deductible does not apply [If services are rendered by a network provider or within a hospital setting, 100% reimbursement applies with no co-pay]	
Acupuncture	100% after $20 co-pay up to a maximum benefit of $1,000/year	80% after deductible up to a maximum benefit of $1,000/year
	[Network and non-network benefits are combined for a maximum of $1,000 per calendar year]	
Chiropractic care	100% after $20 co-pay up to a maximum benefit of $1,000/year	80% after deductible up to a maximum benefit of $1,000/year
	[Network and non-network benefits are combined for a maximum of $1,000 per calendar year]	

Benefits	*Aetna Vision Discount discounted fee*
Frames	
Priced up to $60.99 retail	40 per cent off retail
Priced from $61.00 to $80.99 retail	40 per cent off retail
Priced from $81.00 to $100.99 retail	40 per cent off retail
Priced from $101.00 and up	40 per cent off retail
Lenses — per pair (uncoated plastic)	
Single vision	$40.00
Bifocal	$60.00
Trifocal	$80.00
Standard progressive (no-line bifocal)	$120.00
Lens options — per pair (add to lens prices above)	
Polycarbonate	$40.00
Scratch-resistant coating	$15.00
Ultraviolet coating	$15.00
Solid or gradient tint	$15.00
Glass	20 per cent off retail
Photochromic	20 per cent off retail
Anti-reflective coating	$45.00

Annex V

HIP Health Plan of New York

Plan outline

The HIP plan is an HMO and follows the concept of total prepaid group practice hospital and medical care. This means that there is no out-of-pocket cost to the staff member for covered services at numerous participating medical groups in the Greater New York area.

In addition, prescription drugs (a $5 co-payment applies) and medical appliances (in full) are covered when obtained through HIP participating pharmacies and are prescribed by HIP physicians or any physician in a covered emergency.

This annex will provide a high-level summary chart of the plan. For detailed information staff members must review the HIP Health Plan of New York Plan Description document available at www.un.org/insurance.

Effective 1 July 2013, the HIP plan is closed to new subscribers (i.e. staff members or retirees). Subscribers who are currently covered may remain in the plan, and any changes related to eligible household members will be accepted. However, a current subscriber who switches to another United States plan during the 2013 annual campaign will not be allowed to return to the HIP plan in future annual campaigns.

HIP Health Plan of New York summary of benefits

Benefits	*Coverage*
Hospital services and related care	
Inpatient – Unlimited days — semi-private room & board – Hospital-provided services – Routine nursing care	100%
Outpatient – Surgery and ambulatory surgery – Pre-surgical testing (performed within 7 days of scheduled surgery) – Chemotherapy and radiation therapy – Mammography screening and cervical cancer screening	100%
Emergency room/facility (initial visit) – Accidental injury – Sudden and serious medical condition	100%
Ambulance	100%
Home health care	
– Up to 200 visits per calendar year	100%
– Home infusion therapy	100%
Outpatient kidney dialysis Home, hospital-based or free-standing facility treatment	100% after $10 co-pay
Skilled nursing facility Unlimited days per calendar year	100%
Hospice Up to 210 days per lifetime	100%
Physician services	
Office or home visits/office consultations	100%
Surgery	100%
Surgical assistant	100%
Anaesthesia	100%
Inpatient visits/consultations	100%
Maternity care	100%
Artificial insemination/unlimited procedures based on New York State mandate	100%
Diagnostic X-rays, MRI, CAT scans	100%
Lab tests	100%
Inpatient hospital private duty nursing	100%
Cardiac rehabilitation	100%
Second surgical opinion	100%
Second medical opinion for cancer diagnosis	100%

Benefits	*Coverage*
Allergy testing and allergy treatment	100%
Prosthetic, orthotic and durable medical equipment	100%
Medical supplies	100%
Preventive care	
Annual physical exam	100%
Diagnostic screening test	100%
Prostate specific antigen (PSA) test	100%
Well-woman care (no referral needed)	100%
Mammography screening/Pap smears	100%
Well-child care (including recommended immunizations)	100%
– Newborn baby	1 in-hospital exam at birth
– Birth to 1 year of age	6 visits
– 1 through 2 years of age	3 visits
– 3 through 6 years of age	4 visits
– 7 up to 19th birthday	6 visits
Physical therapy and other skilled therapies	
Physical therapy	
Up to 90 inpatient days per calendar year	100%
Physical therapy (benefit combined with occupational, respiratory and speech)	
– 90 inpatient visits	100%
– 90 outpatient visits	100%
Occupational, respiratory, speech (benefit combined with physical therapy)	
– 90 inpatient visits	100%
– 90 outpatient visits	100%
Behavioural health and substance abuse services	
Mental health care	100%
Outpatient alcohol and substance abuse	100%
Inpatient alcohol and substance abuse/rehab	100%
Prescription drug benefits	
Pharmacy	100% after $5 co-pay for generic/brand, 30-day supply

Benefits	*Coverage*
Mail Order Programme	100% after $2.50 co-pay for generic/brand, 30-day supply
Vision Care Programme	
Through a designated group of providers	100% for 1 exam every 12 months 100% after $45 co-pay for frames and lenses from a select group every 24 months
Other health care	
Acupuncture/yoga/massage	Discounted rates
Chiropractic care (no referral needed)	100%

Annex VI

Cigna Dental PPO

Plan outline

The dental PPO programme offers a large network of participating providers in the Greater New York Metropolitan area and nationally. A dental PPO functions like a medical PPO: the network of dentists who participate in the Cigna dental PPO plan accept as payment a fee schedule negotiated with Cigna. When covered services are rendered by an in-network provider, Cigna reimburses the dentist according to the schedule and the participant normally has no out-of-pocket expense.

This annex will provide a high-level summary chart of the plan. For detailed information, subscribers must review the Cigna Dental PPO plan description document available at www.un.org/insurance.

Cigna Dental PPO summary of benefits

Benefits	*In-network*		*Out-of-network*	
Plan year maximum — 1 July 2012-30 June 2013 (Class I, II and III expenses)	Year 1: $2,250 Year 2: $2,350 Year 3: $2,450 Year 4: $2,550		Year 1: $2,250 Year 2: $2,350 Year 3: $2,450 Year 4: $2,550	
Maximum amounts in years 2-4 are dependent on Class I services being rendered.				
Plan year deductible — 1 July 2012-30 June 2013	$0		$50 per person $150 per family	
Reimbursement levels	Based on reduced contracted fees		Based on reasonable and customary allowances	
	Plan pays	*You pay*	*Plan pays*	*You pay*
Class I — Preventive and diagnostic care Oral exams routine cleanings Full mouth X-rays Bitewing X-rays Panoramic X-rays Periapical X-rays Fluoride application Sealants space maintainers Emergency care to relieve pain Histopathologic exams	100%	No charge	90%	10%
Class II — Basic restorative care Fillings Root Canal Therapy/Endodontics Osseous Surgery Periodontal Scaling and Root Planning Denture Adjustments and Repairs Oral Surgery — Simple Extractions Oral Surgery — all except simple extractions Anesthetics Surgical Extractions of impacted teeth Repairs to bridges, crowns and inlays	100%	0%	80%	20%
Class III — Major restorative care Crowns Surgical implants Dentures Bridges inlays/onlays Prosthesis over implant	100%	0%	80%	20%

	Plan pays	*You pay*	*Plan pays*	*You pay*
Class IV — Orthodontia lifetime maximum	100% $2,250 dependent children up to age 19	0%	70% $2,250 dependent children up to age 19	30%

Note: This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in the insurance certificate or plan description. Benefits are insured and/or administered by Connecticut General Life Insurance Company. Cigna Dental refers to the following operating subsidiaries of Cigna Corporation: Connecticut General Life Insurance Company, and Cigna Dental Health, Inc., and its operating subsidiaries and affiliates. The Cigna Dental Care plan is provided by Cigna Dental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., Cigna Dental Health of Florida, Inc., a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes, Cigna Dental Health of Kansas, Inc. (Kansas and Nebraska), Cigna Dental Health of Kentucky, Inc., Cigna Dental Health of Maryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of Pennsylvania, Inc., Cigna Dental Health of Texas, Inc., and Cigna Dental Health of Virginia, Inc. In other states, the Cigna Dental Care plan is underwritten by Connecticut General Life Insurance Company or Cigna HealthCare of Connecticut, Inc. and administered by Cigna Dental Health, Inc. The term "DHMO" is used to refer to product designs that may differ by state of residence of enrolee, including but not limited to, prepaid plans, managed care plans, and plans with open access features. The Cigna Dental PPO is underwritten and/or administered by Connecticut General Life Insurance Company with network management services provided by Cigna Dental Health, Inc. For Arizona/Louisiana residents the dental PPO plan is known as CG Dental PPO. In Texas, Cigna Dental's network-based indemnity plan is known as Cigna Dental Choice. The Cigna Traditional plan is underwritten or administered by Connecticut General Life Insurance Company. In Arizona and Louisiana, the Cigna Traditional plan is referred to as CG Traditional.

Annex VII

FrontierMEDEX

FrontierMEDEX is a facility available to Aetna and Empire Blue Cross subscribers. The 2013 monthly cost per subscriber is $0.20 and is built into the premium schedule for Aetna and Empire Blue Cross as set out in Annex I.

FrontierMEDEX is a programme providing emergency medical assistance management — including coordinating emergency evacuation and repatriation — and other travel assistance services when the staff member is 100 or more miles from home. Below is a summary of the management coordination services provided.

Medical assistance services

Worldwide referrals: Worldwide medical and dental referrals are provided to help the participant locate appropriate treatment or care.

Monitoring of treatment: FrontierMEDEX Assistance Coordinators will continually monitor the participant's case and FrontierMEDEX Physician Advisors will provide the participant with consultative and advisory services, including the review and analysis of the quality of medical care being received.

Facilitation of hospital payment: Upon securing payment or a guarantee to reimburse, FrontierMEDEX will either wire funds or guarantee the required emergency hospital admittance deposits.

Transfer of insurance information to medical providers: FrontierMEDEX will assist the participant with hospital admission, such as relaying insurance benefit information, to help prevent delays or denials of medical care. FrontierMEDEX will also assist with discharge planning.

Medication, vaccine and blood transfers: In the event medication, vaccine or blood products are not available locally, or a prescription medication is lost or stolen, FrontierMEDEX will coordinate their transfer to the participant upon the prescribing physician's authorization, if it is legally permissible.

Replacement of corrective lenses and medical devices: FrontierMEDEX will coordinate the replacement of corrective lenses or medical devices if they are lost, stolen, or broken during travel.

Dispatch of doctors/specialists: In an emergency where the participant cannot adequately be assessed by telephone for possible evacuation, or cannot be moved, and local treatment is unavailable, FrontierMEDEX will send an appropriate medical practitioner to the participant.

Medical records transfer: Upon the participant's consent, FrontierMEDEX will assist with the transfer of medical information and records to the participant or to the treating physician.

Continuous updates to family, employer and physician: With the participant's approval, FrontierMEDEX will provide case updates to appropriate individuals designated in order to keep family, employer and physicians informed.

Hotel arrangements for convalescence: FrontierMEDEX will assist with the arrangement of hotel stays and room requirements before and after hospitalization.

Medical evacuation and repatriation services

Emergency medical evacuation: If the participant sustains an injury or suffers a sudden and unexpected illness and adequate medical treatment is not available locally, FrontierMEDEX will arrange for a medically supervised evacuation to the nearest medical facility capable of providing appropriate medical treatment. The participant's medical condition and situation must be such that, in the professional opinion of the health-care provider and FrontierMEDEX, the participant requires immediate emergency medical treatment, without which there would be a significant risk of death or serious impairment. Please note that the cost of the evacuation is not covered by FrontierMEDEX.

Transportation to join a hospitalized member: If the participant is travelling alone and is or will be hospitalized for more than seven days, FrontierMEDEX will coordinate round-trip airfare for a person of the participant's choice to join the participant. Please note that the cost of the airfare is not covered by FrontierMEDEX.

Return of dependent children: If the participant's dependent child(ren) age 18 or under are present but left unattended as a result of the participant's injury or illness, FrontierMEDEX will coordinate for one-way airfare to send them back to the participant's home country. FrontierMEDEX will also arrange for the services and transportation expenses of the participant's qualified escort, if required. Please note that the costs of the airfare and escort services are not covered by FrontierMEDEX.

Transportation after stabilization: Following emergency medical evacuation and stabilization, FrontierMEDEX will coordinate for one-way airfare to the participant's point of origin. If following stabilization FrontierMEDEX determines that hospitalization or rehabilitation should occur in the participant's home country, FrontierMEDEX will alternatively coordinate for the participant's transportation there. Please note that the cost of the transportation is not covered by FrontierMFDEX.

Repatriation of mortal remains: If the participant sustains an injury or suffers a sudden and unexpected illness that results in death, FrontierMEDEX will assist in obtaining the necessary clearances for the participant's cremation or the return of the participant's remains. FrontierMEDEX will coordinate the expenses for preparation and transportation of the participant's mortal remains to the participant's home country. Please note that the cost of the transportation is not covered by FrontierMEDEX.

The following services do not fall within the purview of health insurance, but are, nevertheless, included in the monthly FrontierMEDEX fee paid by participants in the Aetna and Blue Cross plans:

Travel assistance services

Emergency travel arrangements: FrontierMEDEX will make new reservations for airlines, hotels, and other travel services in the event of an illness or injury.

Transfer of funds: FrontierMEDEX will provide an emergency cash advance subject to FrontierMEDEX first securing funds from the participant or participants.

Replacement of lost or stolen travel documents: FrontierMEDEX will assist in taking the necessary steps to replace passports, tickets and other important travel documents.

Legal referrals: Should legal assistance be required, FrontierMEDEX will direct the participant to an attorney and assist in securing a bail bond.

Interpretation services: FrontierMEDEX's multilingual Assistance Coordinators are available to provide immediate verbal interpretation assistance in a variety of languages in an emergency; otherwise FrontierMEDEX will provide referrals to local interpreter services.

Message transmittals: The participant may send and receive emergency messages toll-free, 24 hours a day, through the FrontierMEDEX Emergency Response Centre.

Personal security services

Security evacuation services: In the event of a threatening situation, FrontierMEDEX will assist in making evacuation arrangements, including flight arrangements, securing visas, and logistical arrangements such as ground transportation and housing. In more complex situations, FrontierMEDEX will assist in making arrangements with providers of specialized security services. Please note that the cost of the evacuation is not covered by FrontierMEDEX.

Transportation after security evacuation: Following a Security Evacuation and when safety allows, FrontierMEDEX will coordinate for one-way airfare to the participant's home country or host country. Please note that the cost of the evacuation is not covered by FrontierMEDEX.

Online services

Member Centre: Participants have access to FrontierMEDEX's Member Centre, which includes detailed information on the FrontierMEDEX programme, as well as medical and security information for more than 230 countries and territories around the world. To activate the Member Centre account:

1. Visit https://members.medexassist.com.
2. In the Log In box, select "Create User".
3. Enter the FrontierMEDEX ID Number for the United Nations (33211).
4. Accept the User Agreement.
5. Enter in your personal account information to designate yourself a unique username and password.

FrontierMEDEX 360°m Global Medical Monitor: The participant will have online access to continuous updates on health information pertinent to your destination(s) of travel such as immunizations, vaccinations, regional health concerns, entry and exit requirements, and transportation information. Risk ratings are provided for each country and rank the severity of risk concerning disease, quality of care, access to care, and cultural challenges.

World Watch® Global Security Intelligence: The participant will have online access to the latest authoritative information and security guidance for over 170 countries and 280 cities. Information includes the latest news, alerts, risk ratings, and a broad array of destination information including crime, terrorism, local hospitals, emergency phone numbers, culture, weather, transportation information, entry and exit requirements, and currency.

The FrontierMEDEX global security and medical databases are continuously updated and include intelligence from thousands of worldwide sources. This information is also available upon request by calling the FrontierMEDEX Emergency Response Centre.

Custom travel reports: Using the 360°m Global Medical Monitor and World Watch® online intelligence tools, the participant is able to create customized, printable health and security profiles by destination.

Hot spots travel alerts: Subscribe through the Member Centre to receive this free weekday e-mail snapshot of security events from around the world. Listed by region and destination, this bulletin provides a quick review of events that could have a significant impact on travellers. Each event summary includes country threat levels and significant dates.

Conditions and limitations

The services described above are available to the participant only during the participant's enrolment period and only when the participant is 100 or more miles away from his/her residence.

How to use FrontierMEDEX access services 24 hours a day, 7 days a week, 365 days a year

If participants have a medical problem, call the toll-free number of the country you are in (see list below), or call collect the 24-hour FrontierMEDEX Emergency Response Centre in Baltimore, Maryland:

Phone: +1-410-453-6330
Internet: www.FrontierMEDEX.com
E-mail: operations@FrontierMEDEX.com

A multilingual assistance coordinator will ask for your name, your company or group name, the United Nations FrontierMEDEX ID number — 33211 — and a description of your situation.

If the condition is an emergency, go immediately to the nearest physician or hospital without delay and then contact the FrontierMEDEX Emergency Response Centre. It will then take the appropriate action to provide assistance and monitor care.

International toll-free telephone access numbers[a]

Listed below are the telephone numbers for the worldwide FrontierMEDEX Assistance network. If you have a medical or travel problem, call FrontierMEDEX. Printed on your ID card are the telephone numbers for the worldwide FrontierMEDEX network. Call the toll-free number for the country you are in if one is available. If you are in a country that is not listed, or if the call will not go through, please call the Baltimore, Maryland coordination centre collect. Be prepared to give FrontierMEDEX your name, identification number, organization's name, and a brief description of your problem.

[a] The asterisk (*) indicates that the caller should dial the first portion of the phone number, wait for the tone, and then dial the remaining numbers.

Australia, including Tasmania	1-800-127-907
Austria	0-800-29-5810
Belgium	0800-1-7759
Brazil	0800-891-2734
China (northern)*	108888 (wait for tone) 800-527-0218
China (southern)*	10811 (wait for tone) 800-527-0218
Dominican Republic	1-888-567-0977
Egypt (inside Cairo)*	2-510-0200 (wait for tone) 877-569-4151
Egypt (outside of Cairo)*	022-510-0200 (wait for tone) 877-569-4151
Finland	0800-114402
France and Monaco	0800-90-8505
Germany	0800 1 811401
Greece	00-800-4412-8821
Hong Kong, China	800-96-4421
Indonesia	001-803-1471-0621
Ireland (Eire)	1-800-409-529
Israel	1-809-41-0172
Italy, Vatican City and San Marino	800-877-204
Japan	00531-11-4065
Mexico	001-800-101-0061
Netherlands	0800-022-8662
New Zealand	0800-44-4053
Philippines	1-800-1-111-0503
Portugal	800-84-4266
Republic of Korea	00798-1-1-004-7101
Singapore	800-1100-452
South Africa	0800-9-92379
Spain and Majorca	900-98-4467
Switzerland and Liechtenstein	0800-55-6029
Thailand	001-800-11-471-0661
Turkey	00-800-4491-4834

United Kingdom of Great Britain and Northern Ireland, Isle of Jersey, the Channel Isles and Isle of Man	0800-252-074
United States of America, Canada, Puerto Rico, United States Virgin Islands, Bermuda	1-800-527-0218

FrontierMEDEX assistance coordination centre (call collect)

United States: Baltimore, Maryland [1]-410-453-6330

Notes:

When a toll-free number is not available, travellers are encouraged to call FrontierMEDEX collect. The toll-free numbers listed are only available when physically calling from within the country. We strongly encourage you to note this in your printed material to avoid confusion.

The toll-free Israel line is not available from payphones and there is a local access charge.

The toll-free Italy, Vatican City and San Marino number has a local charge for access.

In Italy operator assisted calls can be made by dialling 170. This will give you access to the international operator.

The toll-free Japan line is only available from touchtone phones (including payphones) equipped for international dialling.

If calling from Mexico on a payphone, the payphone must be a La Date payphone.

When calling the China phone numbers please dial as follows:

Northern regions — first dial 10888, then wait a second to be connected. After being connected, dial the remaining numbers.

Southern regions — first dial 10811, then wait a second to be connected. After being connected, dial the remaining numbers.

When calling the Egypt phone numbers please dial as follows:

Inside Cairo — first dial 510-0200, then wait a second to be connected. After being connected, dial the remaining numbers.

Outside Cairo — first dial 02-510-0200, then wait a second to be connected. After being connected, dial the remaining numbers.

International callers who are unable to place toll-free calls to FrontierMEDEX

Many telephone service providers, such as cell phone, payphone and other commercial phone venues, charge for, or outright bar, toll-free calls on their networks. These callers should be instructed to try calling collect. If that is not an option, they will need to dial our number directly and provide a number to which FrontierMEDEX may immediately call back.

Annex VIII

ActiveHealth wellness programme

The ActiveHealth programme was implemented in December 2008 as a health management service that provides confidential disease management and wellness programmes to Aetna and Empire Blue Cross health insurance plan participants. Disease Management and Wellness programmes work to reduce preventable conditions which are often precursors to more serious and chronic conditions. ActiveHealth provides important care considerations to participants and their doctors and assists in managing the health concerns of participants through the services noted below. Staff members may be contacted by ActiveHealth, or can elect to participate in this programme through self-referral by calling ActiveHealth at 1-800-778-8351, or by enrolling at www.myactivehealth.com/unitednations.

- CareEngine and Care Considerations: personalized and confidential communications to patients and physicians to improve the quality of care
- Nurse Care Programme: nurse coaching for members with chronic conditions
- MyActiveHealth: online personal health record
- 24-hour informed health line
- NuVal™: nutritional scoring system

Care engine and care considerations

ActiveHealth is "powered" by the CareEngine® System that applies thousands of evidence-based clinical rules to aggregated member medical, pharmacy, and lab claims along with self-reported data to uncover potential errors and instances of sub-optimal care. The rules are applied on a continuous basis to all members of a covered population to find clinical improvement opportunities. For each potential opportunity identified, a "Care Consideration" is generated that identifies the clinical issue(s) found, and suggests a change in treatment that the evidence-based literature and treatment guidelines indicate would improve the patient's care. These Care Considerations are communicated to treating physicians each time a potential care improvement opportunity is identified by the CareEngine system. Since the physician may have information about the patient that is not available to ActiveHealth, the decision of whether to implement a Care Consideration is up to the physician.

Nurse Care Programme

Members participating in the Disease Management programme are assigned to a Nurse Care Manager who acts as their "personal health coach" around their specific conditions. The Nurse Care Manager provides one-on-one education and support to the member in understanding his/her health needs and how to best leverage physician visits through informed communication.

Disease Management provides comprehensive support for more than 30 chronic conditions that:

- Focuses on both physicians and patients in effecting behaviour changes leading to improved clinical and financial outcomes.

- Identifies and targets impactable clinical issues that are communicated to physicians and patients with specific actions that can be taken to improve patient care.
- Customizes member engagement and education activities and intensity according to the member's specific clinical issues and medical needs.
- Creates a strong value proposition in that it targets resources to those members most likely to benefit from disease management interventions.
- Designs interventions and plans of care around the member's complete set of conditions and co-morbidities in order to maximize care and anticipate potentially harmful interactions between disease states.

The following is a list of the 34 conditions included in the ActiveHealth Nurse Care Programme:

Vascular

- Peripheral artery disease
- Cerebrovascular disease/stroke
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Hypertension — adult and paediatrics
- Hyperlipidemia hypercoagulable state (blood clots)

Diabetes — adult and paediatrics

Pulmonary

- Asthma — adult and paediatrics
- Chronic obstructive pulmonary disease (COPD)

Orthopedic/Rheumatologic

- Rheumatoid arthritis (RA)
- Osteoporosis
- Osteoarthritis (OA)

Gastrointestinal

- Gastroesophageal reflux disease (GERD)
- Chronic hepatitis B or C
- Peptic ulcer disease
- Inflammatory bowel disease (Crohn's disease and ulcerative colitis)

Neurologic conditions

- Seizure disorders
- Migraines
- Parkinsonism
- Geriatrics

Geriatrics

Cancer

- Cancer (general)
- Breast cancer
- Lung cancer
- Lymphoma/leukemia
- Prostate cancer
- Colorectal cancer

Renal

- Chronic kidney disease
- End stage renal disease

Other

- Cystic fibrosis — adult and paediatrics
- HIV
- Chronic back/neck pain
- Sickle cell disease — adult and paediatrics
- Weight management (obesity) — adult and paediatrics

MyActiveHealthSM: personal health record

MyActiveHealth is a simple yet powerful online tool that identifies opportunities for improvements in care. It also identifies prescriptions and over-the-counter drugs that should not be mixed and provides alerts to alternative treatment opportunities to you and your family. The online tool allows you to:

- Store and easily retrieve information about doctor visits, prescriptions, test results, immunizations and even family medical history.
- Access to your medical files securely anywhere the Internet is available — at home, at work, or even in the doctor's office.
- Share information with doctors, family members or caregivers by either printing out the records or granting online access.
- Provide doctors with a more complete picture of your health (if you choose to share it) and promotes better interaction with your doctor.
- Give each family member his or her own personal record to help keep things organized.

Access the MyActiveHealth website at www.myactivehealth.com/unitednations.

24-hour informed health line

- 24/7 telephone access to registered nurses by calling 1-800-556-1555
- Audio library on thousands of health topics such as common conditions/ diseases, gender/age-specific issues, dental care, mental health, weight loss and much more!
- IHL nurses will work in tandem with the Disease Management programme as well as other coverages the United Nations has in place and will make referrals when appropriate.

NuVal

- Nutritional Scoring System, available via through the MyActiveHealthSM portal, is a unique food labelling system which ranks all foods between 1 and 100; the higher the score, the higher the food's overall nutrition. Members can compare scores within a food category, such as cereals, or across categories, such as beef burgers to veggie burgers.
- This tool enables ActiveHealth members to create personalized shopping lists and meal plans. ActiveHealth nurse care programme coaches will also have access to the database as a tool for reinforcing better eating habits.

Annex IX

Vanbreda insurance benefits summary

The Vanbreda insurance programme indemnifies members, within the limits of the plan, for reasonable and customary charges in respect of medical, hospital and dental treatment for illness, an accident or maternity. The aggregate reimbursement in respect of the total expenses covered by the plan that are incurred by an insured participant shall not exceed $250,000 in any calendar year. The provisions set forth below shall be subject to this limitation. In addition to the maximum reimbursement per calendar year, certain maxima per treatment, procedure, supplies or other services may also apply, depending on the type of service.

This annex will provide a high-level summary chart of the plan. For detailed information staff members must review the Vanbreda plan description document available at www.un.org/insurance or access Vanbreda's website (www.vanbreda-international.com).

General cover — outpatient expenses

	Basic Medical Insurance Plan (BMIP)	*BMIP+Major Medical Benefits Plan (MMBP)*
Doctors' fees (GP) Paramedical fees Pharmacy Lab+medical imaging	80% (see below for restrictions for services received in the United States)	96% (yearly out of pocket of US$ 200 per person per calendar year or US$ 600 per family per calendar year for services received outside of the United States)
Outpatient costs in the United States (please see below for chemotherapy, haemodialysis and radiological treatments)	80% (yearly deductible of US$ 1,200 per person per calendar year or US$ 3,600 per family per calendar year)	96% (yearly out of pocket of US$ 1,200 per person per calendar year or US$ 3,600 per family per calendar year)

Note: Some treatments are subject to prior approval. Please refer to the detailed summary plan description (SPD) on www.vanbreda-international.com for more information.

Specific treatments

	Benefits	*Remarks*
Chemotherapy	100%	Doctors' fees at 80%+MMBP
Radiotherapy	100%	Doctors' fees at 80%+MMBP
Haemodialysis	100%	Doctors' fees at 80%+MMBP
Fertility treatments	80%+MMBP	In vitro fertilization not covered

Note: For chemo and radiotherapy and haemodialysis received in the United States, benefits are subject to prior approval (see below) and failure to comply will result in a penalty.

General cover — hospitalizations (subject to prior approval)

	Benefits	*Remarks*
Bed and board	100% up to a maximum per day	– The maximum per day varies depending on the region – Cover restricted to 100% of a semi-private room or ward for specific areas See details in SPD on our website
Other hospital expenses	100%	
Doctors' fees	80%+MMBP	
Personal expenses	Not covered	

Cover expenses incurred in the United States of America

	Benefits	*Remarks*
Increased deductible	US$ 1,200 per person per calendar year or US$ 3,600 per family per calendar year	Once satisfied, reimbursement from BMIP
Strict enforcement of prior approval for:		
– planned hospitalization – selected outpatient treatments (chemo and radiotherapy, haemodialysis)	After meeting the deductible, see benefits for hospitalizations and specific treatments **A financial penalty is imposed if prior approval was not obtained**	Penalty imposed if prior approval was not granted: – no MMBP (cover restricted to BMIP)

For more information, please check our website.

General cover — Benefits with ceilings

	Benefits	*Ceiling*
Dental	80%	– US$ 1,000 per person per calendar year – carry over from previous year's balance
Optical	80%	US$ 250 per period of 24 months (counted as of date of purchase)
Medical check-up	100%	US$ 750 per person per calendar year
Psychotherapy	100%	US$ 1,000 per person per calendar year (can be waived under certain circumstances — see detailed SPD for more information)
Home hospitalization	100%	US$ 5,000 per illness

Exclusions

- Insured participants who are mobilized or who volunteer for medical service in time of war
- Injuries resulting from motor-vehicle racing or dangerous competitions in respect of which betting is allowed (normal sports competitions are covered)
- Non-medical expenses including spa cures, rejuvenation cures or cosmetic treatment (reconstructive surgery is covered where it is necessary as the result of an accident for which coverage is provided)
- Costs exceeding the reasonable and customary limit for the area in which they are incurred
- Preventive care, other than medical check-up and certain vaccinations
- Costs of travel or transportation (except to first hospital in case of emergency)
- In vitro fertilization
- Medical care that is not medically necessary
- Medical care that is not medically recognized as a treatment for the diagnosis provided
- Long-term care
- Products whose effectiveness has not been sufficiently proved scientifically and which are not generally medically recognized in the medical world (e.g. products containing glucosamine or chondroitin sulphate)
- Elective surgery not resulting from illness, an accident or maternity

Annex X

Provider contact directory

Websites

Online provider directories	*Instructions*
Aetna www.aetna.com/docfind/index.html	1. Click on "Find a doctor". 2. Select the search criteria to be used and enter the geographical information. 3. Select a search category, such as "Specialists", "Aetna Vision Discount locations" or "Medical Hospitals". 4. Under "Select a Plan" choose "Aetna Standard Plans". Then select "Open Choice PPO" from the Health Plan menu. 5. Click on the "start search" button to see the list of providers. If there are matches for the criteria you selected, you will be presented with a summary list of results.
Empire Blue Cross www.empireblue.com	1. Click on "Visitors" or "Members" at the top of the menu in the upper left-hand corner of the home page. 2. Select "Find a Doctor" on the left of the page. This selection allows you to find a doctor or hospital locally or across the country. 3. Follow the prompts depending on your selection.
HIP Health Plan of New York https://www.hipusa.com/employers/allforms.asp	1. Click on "Log In" at centre of page. 2. Choose "Find Doctor" on top of page. 3. Choose "HIP" on right side of page. 4. Select "Member" or "Visitor" and then a "provider type" (PCP, Specialist or Hospital) and select "Continue". 5. Under the title "Select Plan" choose "HIP Prime" and under "Network", select "Prime". 6. You may refine your search by entering the name of a provider, or by proximity: zip code; languages spoken, area of specialization or hospital affiliation.
Cigna www.cigna.com/	1. Select "Provider Directory" at the top of the home page. 2. Select "Dentist" on "What type of provider are you looking for?".

Online provider directories	*Instructions*
	3. Select "Language spoken" preference.
	4. Select "Search by name" and "Enter zip code OR city and state" if you already know the dentist's name.
	5. For a new dentist, select "Enter zip code OR city and state" and select the distance you are willing to travel.
	6. Click on "Next" button.
	7. On "Select your plan" choose "Cigna Dental PPO" or "Cigna Dental EPO" (an in-network only DPPO product).
	8. Select "CORE NETWORK" in the next drop-down menu.
	9. Select "Specialty" on drop-down menu (i.e., Endodontics, General Dentistry, etc.).
	10. Click on "Search" button to view search results.
Vanbreda International	1. Select "Plan Members".
www.vanbreda-international.com	2. Enter your Personal Reference Number and Date of Birth (or password).
	3. Select "Provider list".
	4. Select a Continent and a Country.
	5. If desired, refine your search (specialty, city, ...).
	6. Click "Search".

Note: Staff members are strongly encouraged to establish usernames and passwords to access the insurance carriers' member websites to obtain information on the status of claims, view benefits, request identification cards and print temporary identification cards, among others.

United States-based insurance carriers' addresses and telephone numbers for claims and benefit enquiries

I. Aetna PPO/POS II	Aetna Inc. P.O. Box 981106 El Paso, TX 79998-1106
Tel.: (800) 784-3991	Member Services (benefit/claim questions)
Tel.: (800) 333-4432	Pre-registration of hospital/institutional services
Tel.: (610) 336-1000 ext. 3317763	Aetna PPO/POS II members on travel
Tel.: (800) 784-3991	Participating pharmacy referral
Tel.: (866) 612-3862	Aetna Rx Home Delivery (mail order drugs) P.O. Box 417019, Kansas City, MO 64179-9892
Tel.: (866) 612-3862	Maintenance drug automated refills (credit card)
Tel.: (800) 424-1601	Aetna Behavioral Health
Tel.: (800) 793-8616	Vision One
Tel.: (800) 422-6600	Discount Information on Lasik Surgery
II. Aetna International PPO	Aetna International/Aetna P.O. Box 981543 El Paso, TX 79998-1543 USA
Tel.: 1-800-231-7729 or 1-813-775-0190 (call collect from outside USA)	Member Services (benefit/claim questions)
Tel.: 1-800-231-7729 or 1-813-775-0190 (call collect from outside USA)	Pre-registration of hospital/institutional services
Tel.: 1-800-231-7729 or 1-813-775-0190 (call collect from outside USA)	Participating pharmacy referral
Other numbers	Same as for Aetna PPO/POS II above
III. Empire Blue Cross PPO	Empire Blue Cross Blue Shield PPO Member Services P.O. Box 1407 Church Street Station New York, NY 10008-1407
Tel.: (855) 519-9537	Member Services (benefit/claim questions)

Tel.: (855) 519-9537	Medical Management Programme (precertification for hospital admissions, elective surgery, home care, skilled nursing facilities, second opinion referrals)
Tel.: (855) 519-9537	Empire Behavioral Health Services (prior approval of mental health/substance abuse care)
Tel.: (888) 613-6091	Empire Pharmacy Management Programme/NextRx (prescription card programme and pharmacy network and maintenance drug mail order drug information)
IV. Empire Blue Cross (international benefits and claims)	BlueCard Worldwide Service Center P.O. Box 261630 Miami, FL 33126 USA
Tel.: (800) 810-2583 (804) 673-1177 (call collect from outside USA)	BlueCard World Wide (International Benefits and Claims Services)
Tel.: 866-723-0515	Blue View Vision Attn: Out Of Network (OON) Claims P.O. Box 8504 Mason, OH 45040
V. HIP	HIP Member Services Department 7 West 34th Street New York, NY 10001
Tel.: (800) HIP-TALK ((800) 447-8255)	HIP Member Services Dept. (walk-in service available) 6 West 35th Street New York, NY 10001
Tel.: (888) 447-4833	Hearing/Speech Impaired
Tel.: (877) 774-7693	Chiropractor Hotline
Tel.: (888) 447-2526	Mental Health Hotline
Tel.: (800) 290-0523	Dental Hotline
Tel.: (800) 743-1170	Lasik Surgery (Davis Vision) Hotline
VI. Cigna Dental PPO plan	Cigna Dental P.O. Box 188037 Chattanooga, TN 37422-8037
Tel.: (800) 747-UNUN or (800) 747-8686	Claim submission, identification card requests and customer service
Tel.: (888) DENTALS or (888) 336-8258	For participating provider referrals

VII. FrontierMEDEX	FrontierMEDEX Assistance Corporation P.O. Box 19056 Baltimore, MD 21284
Tel.: (800) 527-0218	Within the United States
Tel.: (410) 453-6330 Call collect outside the United States	FrontierMEDEX Emergency Response Centre, Baltimore, MD
International toll-free access numbers	See detailed listing contained in annex VII
VIII. ActiveHealth	ActiveHealth Management 102 Madison Ave New York, NY 10016
Tel.: (212) 651-8200	Corporate Headquarters
Tel.: (800) 778-8351	ActiveHealth Nurse Care Manager Programme
Tel.: (800) 556-1555	24 Hour Nurse Line
www.activehealthphr.net/unitednations	ActivePHR website

IX. VANBREDA

You can reach Vanbreda 24 hours a day, 7 days a week, 365 days a year. In case of emergency or if you simply have a question, you can contact Vanbreda's multilingual staff in several ways. The contact details are also mentioned on your personal web pages and on your membership card.

	Antwerp office	Kuala Lumpur office	Miami office
	www.vanbreda-international.com		
	mcc001@vanbreda.com		
	+ 32 3 217 68 42	+ 60 3 2178 05 55	+ 1 305 908 91 01
	Vanbreda International NV P.O. Box 69 2140 Antwerpen Belgium	Vanbreda International P.O. Box 10612 50718 Kuala Lumpur Malaysia	Vanbreda International P.O. Box 260790 33126 Miami, FL USA

Toll-free numbers

Wherever feasible, you can call Vanbreda for free through a toll-free number. If there is no toll-free number available for your country of stay, you can use the United Nations-dedicated phone number, which is also mentioned on your membership card. You can find the full list of available toll-free numbers per country on your personal web page.

Disclaimer: This circular provides only a summary of the benefits covered under the United Nations Headquarters insurance programme. Detailed benefit descriptions can be obtained from the website of the Health and Life Insurance Section.